Wyoming Department of Health — Behavioral Health Division

Participant and Guardian Verification Form

Behavioral Health Division,
Developmental Disabilities Section
Phone (307) 777-7115
Fax (307 777-6047

Participant Name:		Waiver:	

After discussing these items with the case manager, the Participant and Guardian (if applicable) shall verify the following:

	Participant	Guardian
1. I have participated in the development of this plan and acknowledge my responsibilities as a waiver participant.	☐ Yes ☐ No	☐ Yes ☐ No
2. The restrictions in the rights and restoration plan have been explained to me along with my responsibilities.	☐ Yes ☐ No	☐ Yes ☐ No
3. I agree with the rights restrictions in this plan.	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
4. I understand how the rights restrictions could be reduced or removed over time.	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
5. I have reviewed my choices through a current provider list and have reviewed the waiver services available.	☐ Yes ☐ No	☐ Yes ☐ No
6. I know I have a choice between home and community based services and the Wyoming Life Resource Center. I understand I can contact the Division to review possible changes to my providers. For this plan, I have made an informed choice about my providers.	☐ Yes ☐ No	☐ Yes ☐ No
7. I have been informed of my right to a Fair Hearing if I am denied a provider, service, or eligibility to the waiver	☐ Yes ☐ No	☐ Yes ☐ No
8. I agree that providers can administer medications as trained.	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A

Comments *(use the above item numbers to describe your comments)*

Participant Signature:	_____	Date:	___/___/_____
Guardian Signature:	_____	Date:	___/___/_____